CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 13050	**Date: January 16, 2025**
	Change Request 13894

SUBJECT: Internet Only Manual Update, Pub. 100-04, Chapter 3 (Inpatient Hospital Billing), Sections 20.1.2.7, 140.2.10, 150.28, 190.7.2.5, and Chapter 4 (Part B Hospital) Section 10.7.2.4 Procedures for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the Internet-Only Manual (IOM) 100-04 Chapter 3; Sections 20.1.2.7, 140.2.10, 150.28, 190.7.2.5, and Chapter 4; Section 10.7.2.4 to update the data elements of the Fiscal Intermediary Shared System (FISS) Extract file created in the outlier reconciliation Lump Sum Utility tool as follows:

- Add the Review Code data element.
- Correct the value code for reporting Device Reduction (FD).

EFFECTIVE DATE: July 1, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 7, 2025

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/20/20.1.2.7/Procedure for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments
R	3/140/140.2.10/Procedure for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments for IRFs
R	3/150/150.28/Procedure for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments
R	3/190/190.7.2.5/ Procedures for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments
R	4/10/10.7.2.4/ Procedures for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 13050	Date: January 16, 2025	Change Request: 13894

SUBJECT: Internet Only Manual Update, Pub. 100-04, Chapter 3 (Inpatient Hospital Billing), Sections 20.1.2.7, 140.2.10, 150.28, 190.7.2.5, and Chapter 4 (Part B Hospital) Section 10.7.2.4 Procedures for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments

EFFECTIVE DATE: July 1, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 7, 2025

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the Internet-Only Manual (IOM) 100-04 Chapter 3; Sections 20.1.2.7, 140.2.10, 150.28, 190.7.2.5, and Chapter 4; Section 10.7.2.4 to update the data elements of the Fiscal Intermediary Shared System (FISS) Extract file created in the outlier reconciliation Lump Sum Utility tool as follows:

- Add the Review Code data element.
- Correct the value code for reporting Device Reduction (FD).

II. GENERAL INFORMATION

A. Background: Currently, the FISS Extract file that is created from the outlier reconciliation process does not include the claim Review Code field as a data element. In addition, the current FISS Extract file layout contains an error with the value code associated with Device Reductions. The current file layout documentation refers to value code D4. This CR shall correct the data element layout to refer to value code FD. This change request shall also document fields added in previous CRs.

B. Policy: No new policy.

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13894.1	The Medicare Contractors shall be aware of the updates to the Internet-Only Manual (IOM) 100-04 Medicare Claims Processing Manual, to add the Review Code field, document fields added in previous Change Requests (CRs), and also corrects the Device Reduction value code	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	of the FISS Extract File in the following Chapters and Sections: o 3/20/20.1.2.7/Procedure for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments o 3/140/140.2.10/Procedure for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments for IRFs o 3/150/150.28/Procedure for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments o 3/190/190.7.2.5/Procedures for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments o 4/10/10.7.2.4/Procedures for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments Note: In Chapter 3, Sections 140.2.10 and 150.28, the bulleted list in step 6 is indented and subsequent step numeration is corrected.									

IV. PROVIDER EDUCATION

None

Impacted Contractors: None

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information:N/A

VI. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

20.1.2.7 - Procedure for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments

(Rev. 13050; Issued: 01-16-25; Effective: 07-01-25; Implementation:07-07-25)

The following is a step-by-step explanation of the procedures that Medicare contractors are to follow if a hospital is eligible for outlier reconciliation:

1) The Medicare contractor shall send notification to the CMS Central Office (not the hospital), via email to outliersIPPS@cms.hhs.gov and regional office that a hospital has met the criteria for reconciliation. Medicare contractors shall include in their notification the provider number, provider name, cost reporting begin date, cost reporting end date, total operating and capital outlier payments in the cost reporting period, the operating CCR or weighted average operating CCR from the time the claims were paid during the cost reporting period eligible for reconciliation and the final settled operating and capital CCR.

2) If the Medicare contractor receives approval from the CMS Central Office that reconciliation is appropriate, the Medicare contractor follows steps 3-14 below. **NOTE**: Hospital cost reports will remain open until their claims have been processed for outlier reconciliation.

3) The Medicare contractor shall notify the hospital and copy the CMS Regional Office and Central Office via email at outliersIPPS@cms.hhs.gov that the hospital's outlier claims are to be reconciled.

4) Prior to running claims in the *Lump Sum Utility, Medicare contractors shall update the applicable provider records in the Inpatient Provider Specific File (IPSF) by entering the final settled operating and capital CCR from the cost report in the operating and capital CCR fields. Specifically, for hospitals paid under the IPPS, Medicare contractors shall enter the revised operating CCR in PSF field 25 -Operating Cost to Charge Ratio and the revised capital CCR in PSF field 47 -Capital Cost to Charge Ratio. No other elements in the IPSF (such as elements related to the DSH and IME adjustments) shall be updated for the applicable provider records in the IPSF that span the cost reporting period being reconciled aside from the elements for the operating and capital CCRs.

   ***NOTE**: The FISS Lump Sum Utility is a Medicare contractor tool that, depending on the elements that are input, will produce an extract that will calculate the difference between the original PPS payment amounts and revised PPS payment amounts into a Microsoft Access generated report. The Lump Sum Utility calculates the original and revised payments offline and will not affect the original claim payment amounts as displayed in various CMS systems (such as NCH).

5) Medicare contractors shall ensure that, prior to running claims through the FISS Lump Sum Utility, all pending claims (e.g., appeal adjustments) are finalized for the applicable provider.

6) Medicare contractors shall only run claims in the Lump Sum Utility that meet the following criteria:

   - Type of Bill (TOB) equals 11X
   - Previous claim is in a paid status (P location) within FISS
   - Cancel date is 'blank'

7) The Medicare contractor reconciles the claims through the applicable IPPS Pricer software and not through any editing or grouping software.

8) Upon completing steps 3 through 7 above, the Medicare contractor shall run the claims through the Lump Sum Utility. The Lump Sum Utility will produce an extract, according to the elements in Table 1 below. **NOTE**: The extract must be importable by Microsoft Access or a similar software program (Microsoft Excel).

9) Medicare contractors shall upload the extract into Microsoft Access or a similar software program to generate a report that contains elements in Table 1. Medicare contractors shall ensure this report is retained with the cost report settlement work papers.

10) For hospitals paid under the IPPS, the Lump Sum Utility will calculate the difference between the original and revised operating and capital outlier amounts. If the difference between the original and revised operating and capital outlier amounts (calculated by the Lump Sum Utility) is positive, then a credit amount (addition) shall be issued to the provider. If the difference between the original and revised operating and capital amounts (calculated by the Lump Sum Utility) is negative, then a debit amount (deduction) shall be issued to the provider. **NOTE**: The difference between the original and revised operating outlier amounts and the difference between the original and revised capital outlier amounts are two distinct amounts calculated by the lump sum utility and are recorded on two separate lines on the cost report.

11) The operating and capital time value of money amounts are two distinct calculations that are recorded separately on the cost report. Medicare contractors shall determine the applicable time value of money amount by using the calculation methodology in §20.1.2.6. If the difference between the original and revised operating and capital outlier amounts is a negative amount then the time value of money is also a negative amount. If the difference between the original and revised operating and capital outlier amounts is a positive amount then the time value of money is also a positive amount. Similar to step 10, if the time value of money is positive, then a credit amount (addition) shall be issued to the provider. If the time value of money is negative, then a debit amount (deduction) shall be issued to the provider. **NOTE**: The time value of money is applied to the difference between the original and revised operating and capital outlier amounts.

12) For cost reporting periods beginning before May 1, 2010, under cost report 2552-96, the Medicare contractor shall record the original operating and capital outlier amounts, the operating and capital outlier reconciliation adjustment amount (the difference between the original and revised operating and capital outlier amounts calculated by the Lump Sum Utility), the operating and capital time value of money and the rate used to calculate the time value of money on lines 50-56, of Worksheet E, Part A of the cost report (**NOTE**: the amounts recorded on lines 50-53 and 55 thru 56 can be positive or negative amounts per the instructions above). The total outlier reconciliation adjustment amount (the difference between the original and revised operating and capital outlier amount (calculated by the Lump Sum Utility) plus the time value of money) shall be recorded on line 24.99 of Worksheet E, Part A. For complete instructions on how to fill out these lines please see § 3630.1 of the Provider Reimbursement Manual, Part II. **NOTE**: Both the operating and capital amounts are combined and recorded on line 24.99 of Worksheet E, Part A.

For cost reporting periods beginning on or after May 1, 2010, under cost report 2552-10, the Medicare contractor shall record the original operating and capital outlier amounts, the operating and capital outlier reconciliation adjustment amounts (the difference between the original and revised operating and capital outlier amounts calculated by the Lump Sum Utility), the operating and capital time value of money and the rate used to calculate the time value of money on lines 90-96, of Worksheet E, Part A of the cost report (**NOTE**: the amounts recorded on lines 90-93 and 95 thru 96 can be positive or negative amounts per the instructions above). The total outlier reconciliation adjustment amount (the difference between the original and revised operating and capital outlier amount (calculated by the Lump Sum Utility) plus the time value of money) shall be recorded on line 69 of Worksheet E, Part A. **NOTE**: Both the operating and capital amounts are combined and recorded on line 69 of Worksheet E, Part A.

13) The Medicare contractor shall finalize the cost report, issue a NPR and make the necessary adjustment from or to the provider.

14) After determining the total outlier reconciliation amount and issuing a NPR, Medicare contractors shall restore the operating and capital CCR(s) elements to their original values (that is, the CCRs used to pay the claims) in the applicable provider records in the IPSF to ensure an accurate history is maintained. Specifically, for hospitals paid under the IPPS, Medicare contractors shall enter the original operating CCR in PSF field 25 -Operating Cost to Charge Ratio and the original capital CCR in PSF field 47 -Capital Cost to Charge Ratio.

If the Medicare contractor has any questions regarding this process it should contact the CMS Central Office via the address and email address provided in §20.1.2.1 (B).

Table 1: Data Elements for FISS Extract

List of Data Elements for FISS Extract
Provider #
Health Insurance Claim (HIC) Number
Document Control Number (DCN)
Type of Bill
Original Paid Date
Statement From Date
Statement To Date
Original Reimbursement Amount (claims page 10)
Revised Reimbursement Amount (claim page 10)
Difference between these amounts
Original Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Revised Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Difference between these amounts
Original Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Revised Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Difference between these amounts
Original Medicare Lifetime Reserve Amount in the first calendar year period (Value Code 08)
Revised Medicare Lifetime Reserve Amount in the first calendar year period (Value Code 08)
Difference between these amounts
Original Medicare Coinsurance Amount in the first calendar year period (Value Code 09)
Revised Medicare Coinsurance Amount in the first calendar year period (Value Code 09)
Difference between these amounts
Original Medicare Lifetime Reserve Amount in the second calendar year period (Value code 10)
Revised Medicare Lifetime Reserve Amount in the second calendar year period (Value code 10)
Difference between these amounts
Original Medicare Coinsurance Amount in the second calendar year period (Value code 11)
Revised Medicare Coinsurance Amount in the second calendar year period (Value code 11)
Difference between these amounts
Original Outlier Amount (Value Code 17)
Revised Outlier Amount (Value Code 17)

List of Data Elements for FISS Extract
Difference between these amounts
Original DSH Amount (Value Code 18)
Revised DSH Amount (Value Code 18)
Difference between these amounts
Original IME Amount (Value Code 19)
Revised IME Amount (Value Code 19)
Difference between these amounts
Original New Tech Add-on (Value Code 77)
Revised New Tech Add-on (Value Code 77)
Difference between these amounts
Original Device Reductions (Value Code *FD*)
Revised Device Reductions (Value Code *FD*)
Difference between these amounts
TOT CHRG – total billed charges (claim page 3)
COV CHRG – total covered charges (claim page 3)
Original Hospital Portion (claim page 14)
Revised Hospital Portion (claim page 14)
Difference between these amounts
Original Federal Portion (claim page 14)
Revised Federal Portion (claim page 14)
Difference between these amounts
Original C TOT PAY (claim page 14)
Revised C TOT PAY (claim page 14)
Difference between these amounts
Original C FSP (claim page 14)
Revised C FSP (claim page 14)
Difference between these amounts
Original C OUTLIER (claim page 14)
Revised C OUTLIER (claim page 14)
Difference between these amounts
Original C DSH ADJ (claim page 14)
Revised C DSH ADJ (claim page 14)
Difference between these amounts
Original C IME ADJ (claim page 14)
Revised C IME ADJ (claim page 14)
Difference between these amounts
Original Pricer Amount
Revised Pricer Amount
Difference between these amounts
Original PPS Payment (claim page 14)
Revised PPS Payment (claim page 14)
Difference between these amounts
Original LTCH DPP Adjustment Amount (claim page 40)
Revised LTCH DPP Adjustment Amount (claim page 40)
Difference between these amounts
Original PPS Return Code (claim page 14)
Revised PPS Return Code (claim page 14)
Original UNCOMP CARE AMT (claim page 40)
Revised UNCOMP CARE AMT (claim page 40)
Difference between these amounts
Original VAL PURC ADJ AMT (claim page 40)
Revised VAL PURC ADJ AMT (claim page 40)

List of Data Elements for FISS Extract
Difference between these amounts
Original READMIS ADJ AMT (claim page 40)
Revised READMIS ADJ AMT (claim page 40)
Difference between these amounts
Original HAC PAYMENT AMT (claim page 40)
Revised HAC PAYMENT AMT (claim page 40)
Difference between these amounts
Original EHR PAY ADJ AMT (claim page 40)
Revised EHR PAY ADJ AMT (claim page 40)
Difference between these amounts
Original PPS-ISLET-ADD-ON-AMT (Value Code Q7)
Revised PPS-ISLET-ADD-ON-AMT (Value Code Q7)
Difference between these amounts
DRG
MSP Indicator (Value Codes 12-16 & 41-43 – indicator indicating the claim is MSP; 'Y' = MSP, 'blank' = no MSP
Reason Code
HMO-IME Indicator
Actual Medicare Reimbursement Indicator (claim page 14)
Supplemental Wage Index (claim page 40)
MS-DRG Severity Code (claim page 10)
PPS Pricer Version Number (claim page 14)
MS-DRG 4-digit code (claim page 10)
Review Code
Filler

140.2.10 - Procedure for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments for IRFs

(Rev. 13050; Issued: 01-16-25; Effective: 07-01-25; Implementation:07-07-25)

The following is a step-by-step explanation of the procedures that Medicare contractors are to follow if an IRF is eligible for outlier reconciliation:

1) The Medicare contractor shall send notification to the CMS Central Office (not the IRF), via the street address or email address provided in §140.2.6 (F), and to the Regional Office that an IRF has met the criteria for reconciliation. Medicare contractors shall include in their notification the provider number, provider name, cost reporting begin date, cost reporting end date, total outlier payments in the cost reporting period, the CCR or weighted average CCR from the time the claims were paid during the cost reporting period eligible for reconciliation and the final settled CCR.

2) If the Medicare contractor receives approval from the CMS Central Office that reconciliation is appropriate, the Medicare contractor shall follow steps 3-14 below. **NOTE**: Hospital cost reports will remain open until their claims have been processed for outlier reconciliation.

3) The Medicare contractor shall notify the IRF and copy the CMS Regional Office and Central Office in writing or via email (through the addresses provided in §140.2.6 (F)) that the IRF's outlier claims are to be reconciled.

4) Prior to running claims in the *Lump Sum Utility, Medicare contractors shall update the applicable provider record in the Provider Specific File (PSF) by entering the final settled CCR from the cost report in the -25 -Operating Cost to Charge Ratio field. No other elements in the PSF shall be

updated for the applicable provider records in the PSF that span the cost reporting period being reconciled aside from the CCR.

a. ***NOTE**: The FISS Lump Sum Utility is a Medicare contractor tool that, depending on the elements that are input, will produce an extract that will calculate the difference between the original PPS payment amounts and revised PPS payment amounts into a Microsoft Access generated report. The Lump Sum Utility calculates the original and revised payments offline and will not affect the original claim payment amounts as displayed in various CMS systems (such as NCH).

5) Medicare contractors shall ensure that, prior to running claims through the FISS Lump Sum Utility, all pending claims (e.g., appeal adjustments) are finalized for the applicable provider.

6) Medicare contractors shall only run claims in the Lump Sum Utility that meet the following criteria:

- *Type of Bill (TOB) equals 11X*
- *Previous claim is in a paid status (P location) within FISS*
- *Cancel date is 'blank'*

7) The Medicare contractor reconciles the claims through the IRF Pricer software and not through any editing or grouping software.

8) Upon completing steps 3 through 7 above, the Medicare contractor shall run the claims through the Lump Sum Utility. The Lump Sum Utility will produce an extract, according to the elements in Table 1 below. **NOTE**: The extract must be importable by Microsoft Access or a similar software program (Microsoft Excel).

9) Medicare contractors shall upload the extract into Microsoft Access or a similar software program to generate a report that contains elements in Table 1. Medicare contractors shall ensure this report is retained with the cost report settlement work papers.

10) For facilities paid under the IRF PPS, the Lump Sum Utility will calculate the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17). If the difference between the original and revised outlier amount is positive, then a credit amount (addition) shall be issued to the provider. If the difference between the original and revised outlier amount is negative, then a debit amount (deduction) shall be issued to the provider.

11) Medicare contractors shall determine the applicable time value of money amount by using the calculation methodology in §140.2.8. If the difference between the original and revised outlier amount (calculated by the Lump Sum Utility) is a negative amount, then the time value of money is also a negative amount. If the difference between the original and revised outlier amount (calculated by the Lump Sum Utility) is a positive amount, then the time value of money is also a positive amount. Similar to step 10, if the time value of money is positive, then a credit amount (addition) shall be issued to the provider. If the time value of money is negative, then a debit amount (deduction) shall be issued to the provider. **NOTE**: The time value of money is applied to the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17).

12) For cost reporting periods beginning before May 1, 2010, under cost report 2552-96, the Medicare contractor shall record the original outlier amount from Worksheet E-3, Part 1 line 1.05, the outlier reconciliation adjustment amount (the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17) calculated by the Lump Sum Utility), the total time value of money and the rate used to calculate the time value of money on lines 50-53, of Worksheet E-3, Part 1 of the cost report (**NOTE**: the amounts recorded on lines 50, 51 and 53 can be positive or negative amounts per the instructions above). The total outlier reconciliation amount (the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17)

calculated by the Lump Sum Utility plus the time value of money) shall be recorded on line 15.99 of Worksheet E-3, Part 1. For complete instructions on how to fill out these lines, see §3633.1 of the Provider Reimbursement Manual, Part II.

a. For cost reporting periods beginning on or after May 1, 2010, under cost report 2552-10, the Medicare contractor shall record the original outlier amount from Worksheet E-3, Part III, line 4, the outlier reconciliation adjustment amount (the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17) calculated by the Lump Sum Utility), the total time value of money and the rate used to calculate the time value of money on lines 50-53, of Worksheet E-3, Part III of the cost report (**NOTE**: the amounts recorded on lines 50, 51 and 53 can be positive or negative amounts per the instructions above). The total outlier reconciliation amount (the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17) calculated by the Lump Sum Utility plus the time value of money) shall be recorded on line 30 of Worksheet E-3, Part 3.

13) The Medicare contractor shall finalize the cost report, issue a*n* NPR and make the necessary adjustment from or to the provider.

14) After determining the total outlier reconciliation amount and issuing a*n* NPR, Medicare contractors shall restore the CCR(s) to their original values (that is, the CCR(s) used to pay the claims) in the applicable provider records in the PSF to ensure an accurate history is maintained. Specifically, for hospitals paid under the IRF PPS, Medicare contractors shall enter the original CCR(s) in PSF field 25 -Operating Cost to Charge Ratio.

Medicare contractors shall contact the CMS Central Office via the mailing address or email address provided in §140.2.6 (F) with any questions regarding this process.

Table 1: Data Elements for FISS Extract

List of Data Elements for FISS Extract
Provider #
Medicare beneficiary identifier
Document Control Number (DCN)
Type of Bill
Original Paid Date
Statement From Date
Statement To Date
Original Reimbursement Amount (claim page 10)
Revised Reimbursement Amount (claim page 10)
Difference between these amounts
Original Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Revised Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Difference between these amounts
Original Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Revised Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Difference between these amounts
Original Outlier Amount (Value Code 17)
Revised Outlier Amount (Value Code 17)
Difference between these amounts
Original DSH Amount (Value Code 18)
Revised DSH Amount (Value Code 18)
Difference between these amounts
Original IME Amount (Value Code 19)
Revised IME Amount (Value Code 19)

List of Data Elements for FISS Extract
Difference between these amounts
Original New Tech Add-on (Value Code 77)
Revised New Tech Add-on (Value Code 77)
Difference between these amounts
Original Device Reductions (Value Code *FD*)
Revised Device Reductions (Value Code *FD*)
Difference between these amounts
Original Hospital Portion (claim page 14)
Revised Hospital Portion (claim page 14)
Difference between these amounts
Original Federal Portion (claim page 14)
Revised Federal Portion (claim page 14)
Difference between these amounts
Original C TOT PAY (claim page 14)
Revised C TOT PAY (claim page 14)
Difference between these amounts
Original C FSP (claim page 14)
Revised C FSP (claim page 14)
Difference between these amounts
Original C OUTLIER (claim page 14)
Revised C OUTLIER (claim page 14)
Difference between these amounts
Original C DSH ADJ (claim page 14)
Revised C DSH ADJ (claim page 14)
Difference between these amounts
Original C IME ADJ (claim page 14)
Revised C IME ADJ (claim page 14)
Difference between these amounts
Original Pricer Amount
Revised Pricer Amount
Difference between these amounts
Original PPS Payment (claim page 14)
Revised PPS Payment (claim page 14)
Difference between these amounts
Original LTCH DPP Adjustment Amount (claim page 40)
Revised LTCH DPP Adjustment Amount (claim page 40)
Difference between these amounts
Original PPS Return Code (claim page 14)
Revised PPS Return Code (claim page 14)
Original Uncompensated Care Amount (claim page 40)
Revised Uncompensated Care Amount (claim page 40)
Difference between these amounts
Original Value-based Purchasing Adjustment Amount (claim page 40)
Revised Value-based Purchasing Adjustment Amount (claim page 40)
Difference between these amounts
Original Hospital Readmissions Reduction Amount (claim page 40)
Revised Hospital Readmissions Reduction Amount (claim page 40)
Difference between these amounts
Original Hospital Acquired Condition Adjustment Amount (claim page 40)
Revised Hospital Acquired Condition Adjustment Amount (claim page 40)
Difference between these amounts
Original Electronic Health Record Adjustment Amount (claim page 40)
Revised Electronic Health Record Adjustment Amount (claim page 40)
Difference between these amounts
Original Islet Isolation Add-on Payment Amount (Value Code Q7)

List of Data Elements for FISS Extract
Revised Islet Isolation Add-on Payment Amount (Value Code Q7)
Difference between these amounts
DRG
MSP Indicator (Value Codes 12-16 & 41-43 - indicator indicating the claim is MSP; 'Y' = MSP, 'blank' = no MSP
Reason Code
HMO-IME Indicator
Actual Medicare Reimbursement Indicator (claim page 14)
Supplemental Wage Index (claim page 40)
MS-DRG Severity Code (claim page 10)
PPS Pricer Version Number (claim page 14)
MS-DRG 4-digit code (claim page 10)
B-Review Code (claim page 14)
Filler

150.28 - Procedure for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments

(Rev. 13050; Issued: 01-16-25; Effective: 07-01-25; Implementation:07-07-25)

The following is a step-by-step explanation of the procedures that Medicare contractors are to follow if a LTCH is eligible for outlier reconciliation:

1) The Medicare contractor shall send notification to the CMS Central Office (not the hospital), via email to outliersIPPS@cms.hhs.gov and CMS Regional Office that a hospital has met the criteria for reconciliation. Medicare contractors shall include in their notification the provider number, provider name, cost reporting begin date, cost reporting end date, total short stay and high cost outlier payments in the cost reporting period, the CCR or weighted average CCR from the time the claims were paid during the cost reporting period eligible for reconciliation and the final settled CCR.

2) If the Medicare contractor receives approval from the CMS Central Office that reconciliation is appropriate, the Medicare contractor shall follow steps 3-14 below. **NOTE**: Hospital cost reports will remain open until their claims have been processed for outlier reconciliation.

3) The Medicare contractor shall notify the hospital and copy the CMS Regional Office and Central Office via email at outliersIPPS@cms.hhs.gov that the hospital's outlier claims are to be reconciled.

4) Prior to running claims in the *Lump Sum Utility, Medicare contractors shall update the applicable provider record in the Provider Specific File (PSF) by entering the final settled CCR from the cost report in the -25 -Operating Cost to Charge Ratio field. No other elements in the PSF shall be updated for the applicable provider records in the PSF that span the cost reporting period being reconciled aside from the CCR.

   ***NOTE**: The FISS Lump Sum Utility is a Medicare contractor tool that, depending on the elements that are input, will produce an extract that will calculate the difference between the original PPS payment amounts and revised PPS payment amounts into a Microsoft Access generated report. The Lump Sum Utility calculates the original and revised payments offline and will not affect the original claim payment amounts as displayed in various CMS systems (such as NCH).

5) Medicare contractors shall ensure that, prior to running claims through the FISS Lump Sum Utility, all pending claims (e.g., appeal adjustments) are finalized for the applicable provider.

6) Medicare contractors shall only run claims in the Lump Sum Utility that meet the following criteria:

- *Type of Bill (TOB) equals 11X*
- *Previous claim is in a paid status (P location) within FISS*
- *Cancel date is 'blank'*

7) The Medicare contractor reconciles the claims through the applicable LTCH Pricer software and not through any editing or grouping software.

8) Upon completing steps 3 through 7 above, the Medicare contractor shall run the claims through the Lump Sum Utility. The Lump Sum Utility will produce an extract, according to the elements in Table 1 below. **NOTE**: The extract must be importable by Microsoft Access or a similar software program (Microsoft Excel).

9) Medicare contractors shall upload the extract into Microsoft Access or a similar software program to generate a report that contains elements in Table 1. Medicare contractors shall ensure this report is retained with the cost report settlement work papers.

10) For hospitals paid under the LTCH PPS, the difference between the Original PPS Payment Amount and Revised PPS Payment Amount from the Lump Sum Utility will reflect the difference between the total original short-stay and high cost outlier payment amount and the revised short-stay and high cost outlier payment amount. If the difference between the original and revised PPS Payment Amount is positive, then a credit amount (addition) shall be issued to the provider. If the difference between the original and revised PPS Payment is negative, then a debit amount (deduction) shall be issued to the provider.

11) Medicare contractors shall determine the applicable time value of money amount by using the calculation methodology in §150.27. If the difference between the Original PPS Payment Amount and Revised PPS Payment Amount from the Lump Sum Utility is a negative amount then the time value of money is also a negative amount. If the difference between the Original PPS Payment Amount and Revised PPS Payment Amount from the Lump Sum Utility is a positive amount then the time value of money is also a positive amount. Similar to step 10, if the time value of money is positive, then a credit amount (addition) shall be issued to the provider. If the time value of money is negative, then a debit amount (deduction) shall be issued to the provider. **NOTE**: The time value of money is applied to the difference between the original PPS Payment Amount and Revised PPS Payment Amount.

12) For cost reporting periods beginning before May 1, 2010, under cost report 2552-96, the Medicare contractor shall record the original PPS amount by summing lines 1.02 and 1.05 from Worksheet E-3, Part I, the outlier reconciliation adjustment amount (the difference between the Original PPS Payment Amount and Revised PPS Payment Amount from the Lump Sum Utility), the total time value of money and the rate used to calculate the time value of money on lines 50-53, of Worksheet E-3, Part I of the cost report (**NOTE**: the amounts recorded on lines 50, 51 and 53 can be positive or negative amounts per the instructions above). The total outlier reconciliation amount (the difference between the original PPS Payment Amount and Revised PPS Payment Amount (from the Lump Sum Utility) plus the time value of money) shall be recorded on line 15.99 of Worksheet E-3, Part I. For complete instructions on how to fill out these lines please see §3633.1 of the Provider Reimbursement Manual, Part II.

13) For cost reporting periods beginning on or after May 1, 2010, under cost report 2552-10, the Medicare contractor shall record the original PPS amount from Worksheet E-3, Part IV line 3, the outlier reconciliation adjustment amount (the difference between the Original PPS Payment Amount and Revised PPS Payment Amount from the Lump Sum Utility), the total time value of money and the rate used to calculate the time value of money on lines 50-53, of Worksheet E-3, Part IV of the cost report (**NOTE**: the amounts recorded on lines 50, 51 and 53 can be positive or negative amounts

per the instructions above). The total outlier reconciliation amount (the difference between the original PPS Payment Amount and Revised PPS Payment Amount (from the Lump Sum Utility) plus the time value of money) shall be recorded on line 20 of Worksheet E-3, Part IV.

14) The Medicare contractor shall finalize the cost report, issue a NPR and make the necessary adjustment from or to the provider.

15) After determining the total outlier reconciliation amount and issuing a NPR, Medicare contractors shall restore the CCR(s) to their original values (that is, the CCRs used to pay the claims) in the applicable provider records in the PSF to ensure an accurate history is maintained. Specifically, for hospitals paid under the LTCH PPS, Medicare contractors shall enter the original CCR(s) in PSF field 25 -Operating Cost to Charge Ratio.

If the Medicare contractor has any questions regarding this process it should contact the Central Office, via email at outliersIPPS@cms.hhs.gov.

Table 1: Data Elements for FISS Extract

List of Data Elements for FISS Extract
Provider #
Medicare beneficiary identifier
Document Control Number (DCN)
Type of Bill
Original Paid Date
Statement From Date
Statement To Date
Original Reimbursement Amount (claim page 10)
Revised Reimbursement Amount (claim page 10)
Difference between these amounts
Original Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Revised Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Difference between these amounts
Original Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Revised Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Difference between these amounts
Original Outlier Amount (Value Code 17)
Revised Outlier Amount (Value Code 17)
Difference between these amounts
Original DSH Amount (Value Code 18)
Revised DSH Amount (Value Code 18)
Difference between these amounts
Original IME Amount (Value Code 19)
Revised IME Amount (Value Code 19)
Difference between these amounts
Original New Tech Add-on (Value Code 77)
Revised New Tech Add-on (Value Code 77)
Difference between these amounts
Original Device Reductions (Value Code *FD*)
Revised Device Reductions (Value Code *FD*)
Difference between these amounts
Original Hospital Portion (claim page 14)
Revised Hospital Portion (claim page 14)
Difference between these amounts
Original Federal Portion (claim page 14)
Revised Federal Portion (claim page 14)

List of Data Elements for FISS Extract
Difference between these amounts
Original C TOT PAY (claim page 14)
Revised C TOT PAY (claim page 14)
Difference between these amounts
Original C FSP (claim page 14)
Revised C FSP (claim page 14)
Difference between these amounts
Original C OUTLIER (claim page 14)
Revised C OUTLIER (claim page 14)
Difference between these amounts
Original C DSH ADJ (claim page 14)
Revised C DSH ADJ (claim page 14)
Difference between these amounts
Original C IME ADJ (claim page 14)
Revised C IME ADJ (claim page 14)
Difference between these amounts
Original Pricer Amount
Revised Pricer Amount
Difference between these amounts
Original PPS Payment (claim page 14)
Revised PPS Payment (claim page 14)
Difference between these amounts
Original LTCH DPP Adjustment Amount (claim page 40)
Revised LTCH DPP Adjustment Amount (claim page 40)
Difference between these amounts
Original PPS Return Code (claim page 14)
Revised PPS Return Code (claim page 14)
Original Uncompensated Care Amount (claim page 40)
Revised Uncompensated Care Amount (claim page 40)
Difference between these amounts
Original Value-based Purchasing Adjustment Amount (claim page 40)
Revised Value-based Purchasing Adjustment Amount (claim page 40)
Difference between these amounts
Original Hospital Readmissions Reduction Amount (claim page 40)
Revised Hospital Readmissions Reduction Amount (claim page 40)
Difference between these amounts
Original Hospital Acquired Condition Adjustment Amount (claim page 40)
Revised Hospital Acquired Condition Adjustment Amount (claim page 40)
Difference between these amounts
Original Electronic Health Record Adjustment Amount (claim page 40)
Revised Electronic Health Record Adjustment Amount (claim page 40)
Difference between these amounts
Original Islet Isolation Add-on Payment Amount (Value Code Q7)
Revised Islet Isolation Add-on Payment Amount (Value Code Q7)
Difference between these amounts
DRG
MSP Indicator (Value Codes 12-16 & 41-43 - indicator indicating the claim is MSP; 'Y' = MSP, 'blank' = no MSP
Reason Code
HMO-IME Indicator
Actual Medicare Reimbursement Indicator (claim page 14)
Supplemental Wage Index (claim page 40)
MS-DRG Severity Code (claim page 10)
PPS Pricer Version Number (claim page 14)
MS-DRG 4-digit code (claim page 10)

List of Data Elements for FISS Extract
B-Review Code (claim page 14)
Filler

190.7.2.5 - Procedures for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments

(Rev. 13050; Issued: 01-16-25; Effective: 07-01-25; Implementation:07-07-25)

The following is a step-by-step explanation of the procedures that Medicare contractors are to follow if an IPF is eligible for outlier reconciliation:

1) The Medicare contractor shall send notification to the CMS Central Office (not the hospital), via the street address and email address provided in §190.7.2.2 (B), and CMS Regional Office that a hospital has met the criteria for reconciliation. Medicare contractors shall include in their notification the provider number, provider name, cost reporting begin date, cost reporting end date, total outlier payments in the cost reporting period, the CCR or weighted average CCR from the time the claims were paid during the cost reporting period eligible for reconciliation and the final settled CCR.

2) If the Medicare contractor receives approval from the CMS Central Office that reconciliation is appropriate, the Medicare contractor shall follow steps 3-14 below. **NOTE**: Hospital cost reports will remain open until their claims have been processed for outlier reconciliation.

3) The Medicare contractor shall notify the hospital and copy the CMS Regional Office and Central Office in writing and via email (through the addresses provided in §190.7.2.2 (B)) that the hospital's outlier claims are to be reconciled.

4) Prior to running claims in the *Lump Sum Utility, Medicare contractors shall update the applicable provider record in the Provider Specific File (PSF) by entering the final settled CCR from the cost report in the -25 -Operating Cost to Charge Ratio field. No other elements in the PSF shall be updated for the applicable provider records in the PSF that span the cost reporting period being reconciled aside from the CCR.

   ***NOTE**: The FISS Lump Sum Utility is a Medicare contractor tool that, depending on the elements that are input, will produce an extract that will calculate the difference between the original PPS payment amounts and revised PPS payment amounts into a Microsoft Access generated report. The Lump Sum Utility calculates the original and revised payments offline and will not affect the original claim payment amounts as displayed in various CMS systems (such as NCH).

5) Medicare contractors shall ensure that, prior to running claims through the FISS Lump Sum Utility, all pending claims (e.g., appeal adjustments) are finalized for the applicable provider.

6) Medicare contractors shall only run claims in the Lump Sum Utility that meet the following criteria:

   - Type of Bill (TOB) equals 11X
   - Previous claim is in a paid status (P location) within FISS
   - Cancel date is 'blank'

7) The Medicare contractor reconciles the claims through the IPF Pricer software and not through any editing or grouping software.

8) Upon completing steps 3 through 7 above, the Medicare contractor shall run the claims through the Lump Sum Utility. The Lump Sum Utility will produce an extract, according to the elements in Table 1 below. **NOTE**: The extract must be importable by Microsoft Access or a similar software program (Microsoft Excel).

9) Medicare contractors shall upload the extract into Microsoft Access or a similar software program to generate a report that contains elements in Table 1. Medicare contractors shall ensure this report is retained with the cost report settlement work papers.

10) For hospitals paid under the IPF PPS, the Lump Sum Utility will calculate the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17). If the difference between the original and revised outlier amount (calculated by the Lump Sum Utility) is positive, then a credit amount (addition) shall be issued to the provider. If the difference between the original and revised outlier amount (calculated by the Lump Sum Utility) is negative, then a debit amount (deduction) shall be issued to the provider.

11) Medicare contractors shall determine the applicable time value of money amount by using the calculation methodology in §190.7.2.4. If the difference between the original and revised outlier amount (calculated by the Lump Sum Utility) is a negative amount then the time value of money is also a negative amount. If the difference between the original and revised outlier amount (calculated by the Lump Sum Utility) is a positive amount then the time value of money is also a positive amount. Similar to step 10, if the time value of money is positive, then a credit amount (addition) shall be issued to the provider. If the time value of money is negative, then a debit amount (deduction) shall be issued to the provider. **NOTE**: The time value of money is applied to the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17).

12) For cost reporting periods beginning before May 1, 2010, under cost report 2552-96, the Medicare contractor shall record the original outlier amount from Worksheet E-3, Part 1 line 1.09, the outlier reconciliation adjustment amount (the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17) calculated by Lump Sum Utility), the total time value of money and the rate used to calculate the time value of money on lines 50-53, of Worksheet E-3, Part 1 of the cost report (**NOTE**: the amounts recorded on lines 50, 51 and 53 can be positive or negative amounts per the instructions above). The total outlier reconciliation amount (the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17) calculated by the Lump Sum Utility plus the time value of money) shall be recorded on line 15.99 of Worksheet E-3, Part 1. For complete instructions on how to fill out these lines please see § 3633.1 of the Provider Reimbursement Manual, Part II.

    For cost reporting periods beginning on or after May 1, 2010, under cost report 2552-10, the Medicare contractor shall record the original outlier amount from Worksheet E-3, Part II line 2, the outlier reconciliation adjustment amount (the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17) calculated by the Lump Sum Utility), the total time value of money and the rate used to calculate the time value of money on lines 50-53, of Worksheet E-3, Part II of the cost report (**NOTE**: the amounts recorded on lines 50, 51 and 53 can be positive or negative amounts per the instructions above). The total outlier reconciliation amount (the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17) calculated by the Lump Sum Utility plus the time value of money) shall be recorded on line 29 of Worksheet E-3, Part II.

13) The Medicare contractor shall finalize the cost report, issue a NPR and make the necessary adjustment from or to the provider.

14) After determining the total outlier reconciliation amount and issuing a NPR, Medicare contractors shall restore the CCR(s) to their original values (that is, the CCRs used to pay the claims) in the applicable provider records in the PSF to ensure an accurate history is maintained. Specifically, for hospitals paid under the IPF PPS, Medicare contractors shall enter the original CCR in PSF field 25 - Operating Cost to Charge Ratio.

Medicare contractors shall contact the CMS Central Office via the address and email address provided in §190.7.2.2 (B) with any questions regarding this process.

Table 1: Data Elements for FISS Extract

List of Data Elements for FISS Extract
Provider #
Medicare beneficiary identifier
Document Control Number (DCN)
Type of Bill
Original Paid Date
Statement From Date
Statement To Date
Original Reimbursement Amount (claim page 10)
Revised Reimbursement Amount (claim page 10)
Difference between these amounts
Original Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Revised Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Difference between these amounts
Original Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Revised Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Difference between these amounts
Original Outlier Amount (Value Code 17)
Revised Outlier Amount (Value Code 17)
Difference between these amounts
Original DSH Amount (Value Code 18)
Revised DSH Amount (Value Code 18)
Difference between these amounts
Original IME Amount (Value Code 19)
Revised IME Amount (Value Code 19)
Difference between these amounts
Original New Tech Add-on (Value Code 77)
Revised New Tech Add-on (Value Code 77)
Difference between these amounts
Original Device Reductions (Value Code *FD*)
Revised Device Reductions (Value Code *FD*)
Difference between these amounts
Original Hospital Portion (claim page 14)
Revised Hospital Portion (claim page 14)
Difference between these amounts
Original Federal Portion (claim page 14)
Revised Federal Portion (claim page 14)
Difference between these amounts
Original C TOT PAY (claim page 14)
Revised C TOT PAY (claim page 14)
Difference between these amounts
Original C FSP (claim page 14)
Revised C FSP (claim page 14)
Difference between these amounts
Original C OUTLIER (claim page 14)
Revised C OUTLIER (claim page 14)
Difference between these amounts
Original C DSH ADJ (claim page 14)
Revised C DSH ADJ (claim page 14)
Difference between these amounts
Original C IME ADJ (claim page 14)
Revised C IME ADJ (claim page 14)
Difference between these amounts

List of Data Elements for FISS Extract
Original Pricer Amount
Revised Pricer Amount
Difference between these amounts
Original PPS Payment (claim page 14)
Revised PPS Payment (claim page 14)
Difference between these amounts
Original LTCH DPP Adjustment Amount (claim page 40)
Revised LTCH DPP Adjustment Amount (claim page 40)
Difference between these amounts
Original PPS Return Code (claim page 14)
Revised PPS Return Code (claim page 14)
Original Uncompensated Care Amount (claim page 40)
Revised Uncompensated Care Amount (claim page 40)
Difference between these amounts
Original Value-based Purchasing Adjustment Amount (claim page 40)
Revised Value-based Purchasing Adjustment Amount (claim page 40)
Difference between these amounts
Original Hospital Readmissions Reduction Amount (claim page 40)
Revised Hospital Readmissions Reduction Amount (claim page 40)
Difference between these amounts
Original Hospital Acquired Condition Adjustment Amount (claim page 40)
Revised Hospital Acquired Condition Adjustment Amount (claim page 40)
Difference between these amounts
Original Electronic Health Record Adjustment Amount (claim page 40)
Revised Electronic Health Record Adjustment Amount (claim page 40)
Difference between these amounts
Original Islet Isolation Add-on Payment Amount (Value Code Q7)
Revised Islet Isolation Add-on Payment Amount (Value Code Q7)
Difference between these amounts
DRG
MSP Indicator (Value Codes 12-16 & 41-43 - indicator indicating the claim is MSP; 'Y' = MSP, 'blank' = no MSP
Reason Code
HMO-IME Indicator
Actual Medicare Reimbursement Indicator (claim page 14)
Supplemental Wage Index (claim page 40)
MS-DRG Severity Code (claim page 10)
PPS Pricer Version Number (claim page 14)
MS-DRG 4-digit code (claim page 10)
B-Review Code (claim page 14)
Filler

10.7.2.4 - Procedures for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments

(Rev. 13050; Issued: 01-16-25; Effective: 07-01-25; Implementation:07-07-25)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

The following is a step-by-step explanation of the procedures that Medicare contractors are to follow if a hospital (or CMHC) is eligible for outlier reconciliation:

1) The Medicare contractor sends notification to the CMS Central Office (not the hospital or CMHC), via the street address and email address provided in §10.11.3.1 and to the CMS Regional Office that a hospital or CMHC has met the criteria for OPPS outlier reconciliation. Medicare contractors shall include in their notification the provider number, provider name, cost reporting begin date, cost reporting end date, total outlier payments in the cost reporting period, the CCR or weighted average CCR from the time the claims were paid during the cost reporting period eligible for reconciliation and the final settled CCR.

2) If the Medicare contractor receives approval from the CMS Central Office and Regional Office that OPPS outlier reconciliation is appropriate, the Medicare contractor follows steps 3-14 below. **NOTE**: Hospital and CMHC cost reports will remain open until their claims have been processed for OPPS outlier reconciliation.

3) The Medicare contractor shall notify the hospital or CMHC and copy the CMS Regional Office and Central Office in writing and via email (through the address provided in §10.11.3.1) that the hospital or CMHC's OPPS outlier claims are to be reconciled.

4) Prior to running claims in the FISS Lump Sum Utility*, Medicare contractors shall update the applicable provider record in the Outpatient Provider Specific File (OPSF) by entering the final settled CCR from the cost report in Outpatient Cost to Charge Ratio field. No other elements in the OPSF shall be updated for the applicable provider records in the PSF that span the cost reporting period being reconciled aside from the CCR.

   ***NOTE**: The FISS Lump Sum Utility is a Medicare contractor tool that, depending on the elements that are input, will produce an extract that will calculate the difference between the original PPS payment amounts and revised PPS payment amounts into a Microsoft Access generated report. The Lump Sum Utility calculates the original and revised payments offline and will not affect the original claim payment amounts as displayed in various CMS systems (such as NCH).

5) Medicare contractors shall ensure that, prior to running claims through the FISS Lump Sum Utility, all pending claims (e.g., appeal adjustments) are finalized for the applicable provider.

6) Medicare contractors shall only run claims in the Lump Sum Utility that meet the following criteria:

   - TOB 12X, 13X, 34X, 75X, 76X or any TOB with a condition code 07
   - Claim has a line item date of service of January 1, 2009 or later that also contains a Pay Method Flag of '0'
   - Previous claim is in a paid status (P location) within FISS
   - Cancel date is 'blank'

7) The Medicare contractor reconciles the claims through the OPPS Pricer software and not through any editing or grouping software.

8) Upon completing steps 3 through 7 above, the Medicare contractor shall run the claims through the Lump Sum Utility. The Lump Sum Utility will produce an extract, according to the elements in Table 1 below. **NOTE**: The extract must be importable by Microsoft Access or a similar software program (Microsoft Excel).

9) Medicare contractors shall upload the extract into Microsoft Access or a similar software program to generate a report that contains elements in Table 1. Medicare contractors shall ensure this report is retained with the cost report settlement work papers.

10) For hospitals paid under the OPPS, the Lump Sum Utility will calculate the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17). If the difference between the original and revised outlier amount is positive, then a credit amount (addition)

shall be issued to the provider. If the difference between the original and revised outlier amount is negative, then a debit amount (deduction) shall be issued to the provider.

11) Medicare contractors shall determine the applicable time value of money amount by using the calculation methodology in §10.7.2.3. If the difference between the original and revised outlier amount (calculated by the Lump Sum Utility) is a negative amount then the time value of money is also a negative amount. If the difference between the original and revised outlier amount (calculated by the Lump Sum Utility) is a positive amount then the time value of money is also a positive amount. Similar to step 10, if the time value of money is positive, then a credit amount (addition) shall be issued to the provider. If the time value of money is negative, then a debit amount (deduction) shall be issued to the provider. **NOTE**: The time value of money is applied to the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17).

12) For cost reporting periods beginning before May 1, 2010, under cost report 2552-96, the Medicare contractor shall record the original outlier amount from Worksheet E, Part B, line 1.02 (prior to the inclusion of line 54 of Worksheet E, Part B), the outlier reconciliation adjustment amount (the difference between the original and revised outlier amount (calculated by the Lump Sum Utility), the total time value of money, the rate used to calculate the time value of money and the sum of lines 51 and 53 on lines 50-54, of Worksheet E, Part B of the cost report (**NOTE**: the amounts recorded on lines 50, 51, 53 and 54 can be positive or negative amounts per the instructions above). The total outlier reconciliation amount (Worksheet E, Part B, line 54) shall be included on Worksheet E, Part B, line 1.02. For complete instructions on how to fill out these lines see §3630.2 of the Provider Reimbursement Manual, Part II.

    For cost reporting periods beginning on or after May 1, 2010, under cost report 2552-10, the Medicare contractor shall record the original outlier amount from Worksheet E, Part B, line 4 (prior to the inclusion of line 94 of Worksheet E, Part B), the outlier reconciliation adjustment amount (the difference between the original and revised outlier amount (calculated by the Lump Sum Utility), the total time value of money, the rate used to calculate the time value of money and the sum of lines 91 and 93 on lines 90-94, of Worksheet E, Part B of the cost report (**NOTE**: the amounts recorded on lines 90, 91, 93 and 94 can be positive or negative amounts per the instructions above). The total outlier reconciliation amount (Worksheet E, Part B, line 94) shall be included on Worksheet E, Part B, line 1.02.

13) The Medicare contractor shall finalize the cost report, issue a NPR and make the necessary adjustment from or to the provider.

14) After determining the total outlier reconciliation amount and issuing a NPR, Medicare contractors shall restore the CCR(s) elements to their original values (that is, the CCRs used to pay the claims) in the applicable provider records in the PSF to ensure an accurate history is maintained. Specifically, for hospitals paid under the OPPS, Medicare contractors shall enter the original CCR in PSF field 25 -Operating Cost to Charge Ratio.

Medicare contractors shall contact the CMS Central Office via the address and email address provided in §10.11.3.1 with any questions regarding this process.

Table 1: Data Elements for FISS Extract

List of Data Elements for FISS Extract
Provider #
Medicare beneficiary identifier
Document Control Number (DCN)
Type of Bill
Original Paid Date
Statement From Date

List of Data Elements for FISS Extract
Statement To Date
Original Reimbursement Amount (claim page 10)
Revised Reimbursement Amount (claim page 10)
Difference between these amounts
Original Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Revised Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Difference between these amounts
Original Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Revised Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Difference between these amounts
Original Outlier Amount (Value Code 17)
Revised Outlier Amount (Value Code 17)
Difference between these amounts
Original DSH Amount (Value Code 18)
Revised DSH Amount (Value Code 18)
Difference between these amounts
Original IME Amount (Value Code 19)
Revised IME Amount (Value Code 19)
Difference between these amounts
Original New Tech Add-on (Value Code 77)
Revised New Tech Add-on (Value Code 77)
Difference between these amounts
Original Device Reductions (Value Code *FD*)
Revised Device Reductions (Value Code *FD*)
Difference between these amounts
Original Hospital Portion (claim page 14)
Revised Hospital Portion (claim page 14)
Difference between these amounts
Original Federal Portion (claim page 14)
Revised Federal Portion (claim page 14)
Difference between these amounts
Original C TOT PAY (claim page 14)
Revised C TOT PAY (claim page 14)
Difference between these amounts
Original C FSP (claim page 14)
Revised C FSP (claim page 14)
Difference between these amounts
Original C OUTLIER (claim page 14)
Revised C OUTLIER (claim page 14)
Difference between these amounts
Original C DSH ADJ (claim page 14)
Revised C DSH ADJ (claim page 14)
Difference between these amounts
Original C IME ADJ (claim page 14)
Revised C IME ADJ (claim page 14)
Difference between these amounts
Original Pricer Amount
Revised Pricer Amount
Difference between these amounts
Original PPS Payment (claim page 14)
Revised PPS Payment (claim page 14)
Difference between these amounts
Original LTCH DPP Adjustment Amount (claim page 40)
Revised LTCH DPP Adjustment Amount (claim page 40)
Difference between these amounts

List of Data Elements for FISS Extract
Original PPS Return Code (claim page 14)
Revised PPS Return Code (claim page 14)
Original Uncompensated Care Amount (claim page 40)
Revised Uncompensated Care Amount (claim page 40)
Difference between these amounts
Original Value-based Purchasing Adjustment Amount (claim page 40)
Revised Value-based Purchasing Adjustment Amount (claim page 40)
Difference between these amounts
Original Hospital Readmissions Reduction Amount (claim page 40)
Revised Hospital Readmissions Reduction Amount (claim page 40)
Difference between these amounts
Original Hospital Acquired Condition Adjustment Amount (claim page 40)
Revised Hospital Acquired Condition Adjustment Amount (claim page 40)
Difference between these amounts
Original Electronic Health Record Adjustment Amount (claim page 40)
Revised Electronic Health Record Adjustment Amount (claim page 40)
Difference between these amounts
Original Islet Isolation Add-on Payment Amount (Value Code Q7)
Revised Islet Isolation Add-on Payment Amount (Value Code Q7)
Difference between these amounts
DRG
MSP Indicator (Value Codes 12-16 & 41-43 - indicator indicating the claim is MSP; 'Y' = MSP, 'blank' = no MSP
Reason Code
HMO-IME Indicator
Actual Medicare Reimbursement Indicator (claim page 14)
Supplemental Wage Index (claim page 40)
MS-DRG Severity Code (claim page 10)
PPS Pricer Version Number (claim page 14)
MS-DRG 4-digit code (claim page 10)
B-Review Code (claim page 14)
Filler